Distortions and maps of wonderland

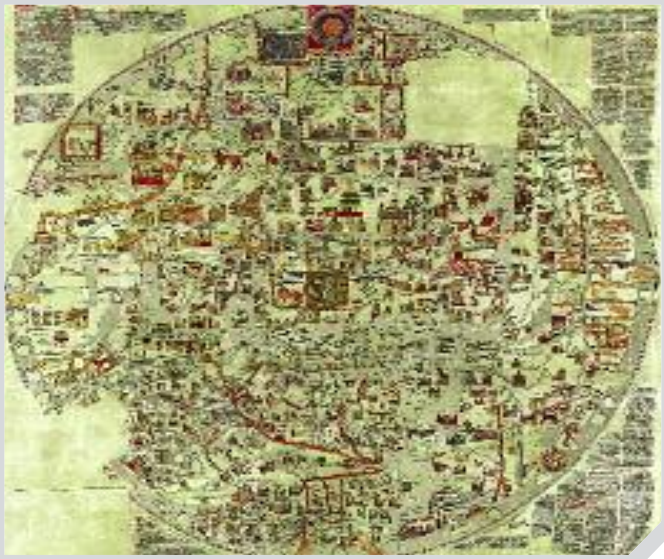
Given the importance they attach to evidence, it is surprising that Essi Viding and Uta Frith (Letters, June) should use the words 'attacking the DSM-5', implying both aggression and lack of justification, for what is in fact a thoughtful, evidence-based statement by the Division of Clinical Psychology (DCP) on psychiatric classification.

In criticising the statement and subsequent 'pronouncements in the media', Viding and Frith present the current situation in mental health as one led by evidence, in which researchers and clinicians take due account of both environmental and biological factors in understanding 'the symptoms that mark mental illness'. This is far from the case. For the last 30 or 40 years, research and practice in this area has been dominated by approaches which privilege genes and biology, depict emotional and behavioural problems as akin to physical illnesses, and systematically de-emphasise the potential causal role of people's social and personal contexts. This is in spite of a poor evidence base for all three of these stances. This situation itself has a social context, which may help explain both its persistence and the strength of feeling often evoked by attempts at change (Boyle, 2011; Cromby et al., 2013; Pilgrim, 2007).

And contrary to Viding and Frith's claims, the DCP argument is not based on a 'false dichotomy between genes and environment'. It does position itself for a reconceptualisation of the role of biology and against a model that sees mental, emotional and behavioural difficulties as symptomatic of biologically based illness. It also argues for due acknowledgement of the vast amount of evidence that many of these difficulties are meaningful responses to often extremely challenging life circumstances.

Finally, Viding and Frith imply that those who claim a causal link between child abuse and 'schizophrenia' are 'not slowed down by a need for an evidence base, but instead irresponsibly make unsubstantiated and alarmist pronouncements'. This is completely unjustified. There is good evidence, some of it cited in the DCP statement, that the links between child abuse and psychosis are likely to be causal, and such claims are not made lightly. This evidence may be difficult for many to hear and unfortunately, Viding and Frith's ad hominem response, rather than one engaging with the evidence, is not untypical.

I hope the DCP statement will encourage truly informed debate on these issues to the benefit of researchers,



Professors Viding and Frith (Letters, June 2013) excoriate critics of DSM-5 who, they say, 'are in danger of muddying mental health issues by ignoring… biology'. They write approvingly of Simon Wessely's *Observer* article (12 May 2013) and endorse his claim that 'a classification system is like a map. And just as any map is provisional, ready to be changed as the landscape changes, so is classification.'

Let me outline how history illustrates the value of this metaphor of mapping the mind.

In 1952, when the first Definitely Scientific Map (let's call it 'DSM-1') was published, only 106 cartographic entities were in the atlas. A good index of the success of the cartographers of the mind is the phenomenal productivity of their subsequent explorations – new islands, continents, rivers, mountain ranges, swamps, and so on, were added, and although many old ones were thrown out they achieved an average rate of increase over the next 42 years of close to one every eight weeks: DSMap-4 (1994) showed 365 entities.

How had they achieved this fecundity? Untiring effort was the answer. Year in, year out their exploration vessels sailed the seven (7.34 ± 1.56) seas, proudly flying the Cartographers' flag, a banner inscribed 'BP'. (Crew members gave different answers when asked what the letters stood for: 'Big Pharma', said some, 'Big-time Psychiatry,' said others, but the groups worked together as one big happy family regardless).

It was not always smooth sailing. For example, when explorers sent descriptions of the landscape to the head office of the Cartographers of the Mind Association (CoMA) for official rulings, one might

clinicians and, above all, service users themselves.

Professor Mary Boyle
University of East London

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We welcome contributions to the debate that has been raised by the DCP Position Statement on Classification, which can be read in full at http://dcp.bps.org.uk/dcp/the_dcp/news/dcp-position-statement-on-classification.cfm

The statement is not about DSM specifically but about conceptual systems 'based on a "disease" model'. This would include ICD. Nor do we see it as an 'attack' but as a thoughtful critique based on a two-year process of reviewing the evidence and consulting within all the DCP Faculties, where it has widespread support.

It is difficult to convey a complex argument through the media. We regret that some of the reporting has badged this as a psychiatry versus psychology battle. We have been working hard to counter this. The statement itself makes it absolutely clear that, to quote: 'This position should not be read as a denial of the role of biology in mediating and enabling all forms of human experience, behaviour and distress… It recognises the complexity of the relationship between social, psychological and biological factors' (p.2).

We are unhappy with responses that, quite wrongly, represent us as presenting 'a false dichotomy between genes and environment' and hope that all members of the Society will take the opportunity to correct such misinterpretations. Nevertheless, our position, supported by a great deal of evidence, is that it is neither accurate nor helpful to conceptualise the experiences that may lead to a functional psychiatric diagnosis within a 'disease' model, in which biological causal factors such as genes or biochemistry are hypothesised to be the primary causal ones. We do not do this for other responses to life events – for example, bereavement – and by analogy, our argument is that the increasing amount of evidence for the causal role of all kinds of traumas and life circumstances in psychiatric breakdown makes it implausible to do so in many of these cases as well. The DCP is, in conjunction with the BPS Media Centre, monitoring the media coverage closely and working to correct any distortions of our message.

The point is well made that we need to explore the possibility of alternative clustering systems, and internationally there are a number of groups engaged in this task. The DCP has funded its own project to outline the principles of an approach that identifies common patterns of responses, both psychological and biological, to life events and social circumstances, and that might supplement and support the use of individual formulation.

Clearly, the existing classification system will be with us for some time. However, the DCP believes that it is vitally important to 'achieve greater openness and transparency about the uses and limitations of the current system' and 'to open up dialogue with partner organisations, service users and carers, voluntary agencies and other professional bodies in order to find agreed ways forward' (p.4).

Richard Pemberton
Chair, BPS Division of Clinical Psychology

be told that a tenant was on Mount Skitzos while a second tenant in the same building was on the Isle of Catatonia, a third on Lake Normalia. But none of this impeded the enlightened help BP could provide to the inhabitants – the holds of the vessels of exploration were brimming with curative chemicals that were equally effective everywhere on the Map.

There were of course sceptics, people who thought, for example, that it might be more effective to build warm buildings in (bi?) polar regions instead of filling inhabitants with chemicals that made them complain less about the cold. As a gesture of goodwill (and to try to rid themselves of the distractions of repetitive complaints), exploration vessels started to carry small amounts of building material, pumps to drain swamps, and so on. CoMA itself even professed to subscribe to a Bio-Psycho-Social model of disorder: their banners accordingly now read 'BPS' not 'BP'. (This new image has perhaps brought to light a little-researched version of the Stockholm syndrome, with scientists who are not members of the BP team taking up cudgels on the team's behalf).

Sceptics even argued that the metaphor itself is flawed. Geographic cartographers, they say, draw representations of things we are reasonably sure exist independently of the maps drawn of them: mountains, islands, and so on, they disingenuously claim, are real. DS Maps of mental disorders, they say, are different. They are not representations of realities: the entities they purport to describe are constructions of the minds of Cartographers of the Mind. They are Maps of Wonderland.

Professor Justin Joffe
London N2

The American critic H.L. Mencken once remarked, 'For every subtle and complicated question, there is a perfectly simple and straightforward answer, which is wrong'. The question of how to respond to psychological distress is subtle and complicated. The answer that has dominated recent Western thinking, namely that there exist mental illnesses and that these are illnesses like any other, has the virtue of being simple and straightforward. But it may also be wrong – or at least, partial, misleading and, in some cases, actively unhelpful.

The DCP's recent statement is to be commended for not trying to replace one 'simple, straightforward and wrong' answer with another. The document acknowledges the subtle and complicated nature of the issues. Contrary to what some commentators have suggested, it does not pit clinical psychology against psychiatry or deny the role of biology – indeed, it states explicitly that what is required is 'multi-factorial and contextual approach, which incorporates social, psychological and biological factors'. It highlights problems with the current system of classification, but does not object to classification *per se*. It offers no off-the-shelf alternative, calling instead for wide-ranging dialogue to develop new approaches. Even the document's most striking

suggestion, a move away from the system of diagnosis described by the DSM-5, is hardly radical. Similar arguments have recently been made by influential and mainstream groups such as Mental Health Europe (see tinyurl.com/bqdgos9) and the US National Institute for Mental Health (see tinyurl.com/cl5ekbc).

That such a measured and non-polemical statement should provoke howls of outrage perhaps tells us something about the tenuous foundations of the medical model. If proponents had the confidence of their convictions they would have nothing to fear from – indeed would welcome – critical interrogation. By contrast, those who raise problems with diagnosis, or with the concept of mental illness as such, are accused of 'anti psychiatry prejudice' and of having no interest in relieving suffering (see tinyurl.com/no88tpb). Most baffling of all is the response that criticising diagnosis is somehow anti-scientific – particularly absurd when, as the DCP statement makes clear, many of the difficulties of the DSM arise from a failure to follow the scientific method.

Although the DCP statement makes no new arguments, it performs a valuable service by bringing vital critiques of the medical model of mental illness to wider public attention. Personally, I am proud to see the BPS finding its voice and raising subtle and complex questions.

Dr Sam Thompson
Institute for Psychology, Health and Society
University of Liverpool

Methodological shortcomings of biological research

I read with interest Essi Viding and Uta Frith's response to the DCP's recent statement concerning DSM-5. They write that the DCP representatives are 'in danger of muddying mental health issues by ignoring the biology' and that 'their present stance will fail to deliver help for those who suffer from mental health problems'. I thought this was a curious response, given the outright failure of behaviour genetics research over several decades to benefit service users in any way whatsoever. This failure to deliver anything of use to those on the sharp end should not be considered surprising given that the case for a genetic basis for the behaviours and experiences which are categorised as serious mental illness has been vastly over-stated.

A recurrent feature in this work has been the poor reliability of diagnostic categories, absence of biological markers and an automatic interpretation that data from twin and family studies favour a genetic interpretation when in actuality the greater genetic similarity of MZ twins compared to DZ twins is confounded by their greater shared environment. It is simply not the case that the equal environments assumption can be so blithely ignored or that the use of structural equation modelling as a research tool can circumvent the problems. It is well known – or at least ought to be – that in any multivariate model where there are two potential predictors of an outcome of interest and these are strongly related (as is the case for genetic similarity and degree of shared environment in twin studies) the one which is measured with greater precision will seem to be the more strongly related with the outcome than is actually the case (Davy Smith & Phillips, 1996; Phillips & Davy Smith, 1991).

Twin studies incorrectly interpreted have led researchers to expect huge genetic effects that have simply not materialised in molecular genetics research. The recent 'breakthroughs' proposing a common genetic pathways in five psychiatric disorders for example (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013) is but one example. The authors were only able to explain between 1 and 2 per cent of the variance in any of the target disorders (ADHD, ASD, bipolar disorder, major depressive disorder, and schizophrenia) with the expressed possibility that their results could have been inflated by diagnostic overlap. Given the sample size they used (over 30,000) the findings may have no clinical significance whatsoever.

Their preference for biological theorising made clear, Viding and Frith, with a rhetorical wave of the hand, then refer to 'unsubstantiated and alarmist pronouncements about child abuse causing schizophrenia'. That child sexual abuse is a risk factor for almost all forms of 'psychopathology' (including schizophrenia) is not unsubstantiated but is in fact well attested by a large body of research (e.g. Roberts et al., 2004). Viding and Frith are of course correct to point out that current interventions (both medical and psychological) are far from effective, but that situation is not likely to improve until the poor track record and methodological shortcomings of biological research in mental health is acknowledged.

Ron Roberts
Kingston University

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NOTICEBOARD

Clinical and counselling psychologists are invited to participate in an international research study on the relationship between **core beliefs, stress and burnout**. This study will help us to develop resilience training to strengthen coping skills amongst psychologists. To access the survey, please go to tinyurl.com/kkbfnfo. This study has been approved by the University of South Australia's Human Research Ethics Committee.

Susan Simpson
susan.simpson@unisa.edu.au

As part of PhD studies at the University of Greenwich I am seeking personal accounts by therapists of **anomalous experiences in, or in connection with, counselling/psychotherapy**. Participation in this study would ask you to complete an online questionnaire.
If you would like further information on the nature and purpose of this research, please go to tinyurl.com/q5qjtsr

Paul Atkinson
ar57@gre.ac.uk

Stepping from the shadow

We are writing to commend the immediate and comprehensive use of the DCP statement on formulation to all of our colleagues. It has appeared at the very time when the shortcomings of psychiatric diagnosis have been exposed in the critical international response to the publication of DSM-5 by the American Psychiatric Association. Our current context then provides the profession of clinical psychology with a unique historical opportunity to adopt a clear position of scientific humanism.

DSM and other forms of psychiatric nosology are incompatible with a psychological approach to helping people with their problems, which should be both humane and scientific. Our approach to helping others should be based on identifying specific problems (defined by clients themselves but, for obvious practical purposes reflecting a common lexicon) and working with them to develop individual and context-bound formulations. These would include the unique events in a person's life past and present, the meanings they invest in, or attribute to, those events and strengths to build upon that he or she has exhibited to date in coping with challenges in their life.

David Pilgrim
Professor of Health and Social Policy
Peter Kinderman
Professor of Clinical Psychology
Richard Bentall
Professor of Clinical Psychology
University of Liverpool

As 210 clinical psychologists and mental health professionals, we support the DCP's call for a paradigm shift in how we think about mental distress and the need to move away from psychiatric diagnosis. We are pleased by the media coverage and the debate this has stimulated in the wider public.

It is essential that diverse voices are heard and that rather than considering individuals as receptacles of disorders, deficits and distortions, we make sense of distress in more helpful and evidence-based ways. We need to focus far more on people's lives, experiences and social contexts and to consider how people embody and are shaped by the world around them.

We note that organisations such as the Hearing Voices Network and Mental Health Europe, which represent the service-user perspective, have recently challenged the diagnostic and professional expert-driven status quo, and we believe that clinical psychology needs to support and work with these groups. We need to step out from the shadow of biological reductionism and consider the multifaceted nature of what it is to be human and to be part of the world around us. We wish to support the DCP and the growing number of service users, carers, professionals and organisations who are questioning the dominant paradigm.

This is a very important step for the profession and one that is long overdue.

Dr Mel Wiseman
Wellingborough
and 209 other signatories
(For the full list see the html version in 'Letters' at www.thepsychologist.org.uk)

Following the publication of the DCP's Position Statement on Diagnosis, which we have already endorsed, the Psychosis and Complex Mental Health Faculty is keen to work on bringing about the changes in practice and conceptualisation that it envisages in our services. Most of us in the Faculty work closely with colleagues in other professions in a team context, so that collaboration, both with them and with service users and carers, is a priority. We are seeking to further this agenda at the Faculty conference and AGM to be held on 20 November at the BPS London office under the heading 'Developing the narrative – Creating a shared paradigm shift towards a holistic view of mental health'.

This should further the process of moving beyond restrictive, illness-based conceptualisations in partnership with the other groups and professions concerned with complex mental health, in line with the second recommendation at the end of the position statement.

Isabel Clarke
Chair of the PCMH Faculty of the DCP on behalf of the Faculty Committee

The recently published Francis Report calls for a change in the culture of the NHS, re-positioning the patient at the centre of care and enshrining values of responsibility and accountability in everyday practice (among 290 recommendations). The stars aligned with the publication of DSM-5 and the DCP's position statement 'Time for a paradigm shift'; this seemed like a timely way to generate debate, about the influence of diagnostic categories on constructions of distress and thus mental health care provision.

The response to the DCP statement from some quarters has left me stunned and greatly concerned for the profession. It makes me think of Menzies-Lyth's (1960) work on socially structured defence mechanisms in the face of anxiety. Some of the defences proposed include atomisation of tasks and the ceding of responsibility to higher-ranking staff. This potentially entrenches hierarchies and negates questioning dominant narratives in services. Bringing this back to the here and now, it seems there is a real danger that a great many healthcare professionals work in systems that do not encourage questioning. This is self-evident following Francis and possibly not confined to the NHS services of Mid Staffordshire. The Francis Report calls for a new culture of patient care, which surely includes a fresh examination of the paradigms that support this care.

This poses a series of questions for commissioners, providers, and practitioners. Do we want healthcare professions not to question? Will this lead to greater responsibility and accountability? Can we put patients' needs in the centre of our practice without critically examining our models, the evidence we draw on, and the language we use to define others' distress? If we don't critically reflect on what we do, whose needs are we serving?

For those that have come out strongly against the DCP position statement I think its positive that a genuine debate might at last happen. And, reflecting on the work of Žižek (2008), can I ask you one last question – in entering the debate in this way have you taken the right step, but the wrong direction?

Ima Nusm
Trainee clinical psychologist
University of East London

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Are we competent to recognise our incompetence?

It is fashionable to seek to connect disparate things, and in response to three parts of *The Psychologist*, June 2013, I offer these thoughts. I want to connect editor Jon Sutton's quote from Bertrand Russell ('One of the painful things about our time is that those who feel certainty are stupid, and those with any imagination and understanding are filled with doubt and indecision') and the letters on the DSM vs. DCP conflicts with the letter about Farrelly's Provocative Therapy.

My challenge to DSM people and DCP people is this: you are incompetent, you have clearly failed to make progress with people's mental health in general and should rethink your position. If you cannot outline a positive way forward then you should all go home.

Examples of failure? Well, an obesity crisis is surely self-harm on a massive scale and almost total failure to create a response to genocidal climate change (killing off a future generation is genocide in my book) shows total disregard for priorities let alone anything else.

My own view of why you are incompetent, that you fail to accept a paradigm of multiplicity – that a persona which might have a biological response system should be switched to a persona which will respond to an environmental response (and vice versa is an option of course: see Rita Carter, Ornstein and even William James) – is not actually relevant. What is relevant is that whatever paradigms you are adopting (and most times you fail to declare them) they are failing and after 90 years of trying you should give up.

For those who think I am singling out clinical I am happy to challenge educational psychology (which paradoxically is regulated through the medical model) that you should also all give up and go home because the school system is not much better if at all from 50 years ago. Likewise, in forensic you fail to make any inroads into prisoner rehabilitation and for organisational psychologists, you are dismal failures when it comes to having any success with governments current and past (as the audit trail shows they aren't even getting the maths right, though maybe that is the fault of the educational psychologists) and even more so with company executives and leadership, management and teamwork, where your pay should yield a better return than the worst recession in decades – why haven't you run over the cliffs like lemmings do? (Or don't to be accurate.)

So, let's own up to our incompetence at recognising our incompetence, give up what we are trying to do and failing, and do something else, help save the planet maybe (but not as psychologists, please).

Graham Rawlinson
Chichester

Public protection – a moral maze

In today's media-focused culture, moral judgements about other people's behaviour are made every second. Most people would probably agree that health and care professionals are given unique trust by the public. However, there is less clarity around the expectations that go with this trust, and the consequences for breaches of trust. Consider the following:

> *A health professional is arrested for shoplifting. Does this have an impact on his fitness to practise?*
>
> *A health professional has been charged with drink-driving after attending a party whilst off duty. She drank four or five glasses of wine – and has not shown a history of alcohol abuse. Does this impact on her ability to do her job?*

The Health and Care Professions Council wanted to explore this complex area in relation to public understanding of 'protection', and what health and care regulators should be doing as the gatekeepers of professional standards. We commissioned a study, to which 270 people contributed, including members of the public, those from patient and service user groups, professionals, educators and employers (read the report at www.hcpc-uk.org/publications/research).

Participants were asked to share their experiences of care, and explore different scenarios like the ones above. The majority saw the first scenario as more serious in relation to fitness to practice. This was because it signified a deliberate, premeditated act, whereas in the second, participants thought it might not impact on a professional's ability to do their job. A comprehensive understanding of the individual circumstances would usually be required to make a judgement about fitness to practise.

This case-by-case consideration of the evidence, taking account of the context in which actions occur, reflects the HCPC's approach to all fitness to practise referrals. Maintaining public safety is paramount. Clearly, a drink-driving conviction is a serious breach of the rules. However, it would likely have greater implications for a professional if they were on duty at the time or travelling to or from work, if it were a repeat offence or if the professional showed no insight into the impact of drink-driving on safety.

There was agreement amongst the participants that repeated behaviour or practice that did not meet standards, a premeditated decision to do something known to be illegal or other dishonest behaviour should trigger an investigation by the regulator. They also agreed that, where actions had consequences for patients or service users, the professional's fitness to practise should be investigated.

In the aftermath of the Francis Report, we are looking closely at this research and its lessons. There are lines that can be drawn, where the majority would agree there are implications for both public safety and public confidence. HCPC standards exist as a framework, a Highway Code, designed to guide. But context is a hugely important factor when making judgements about other people's actions, and informed judgements are almost always about understanding the context. What professionals – and regulators – must do is maintain high levels of self-awareness and moral questioning, which militate against making bad choices, but can never totally eliminate them.

I hope that this report will be discussed by patient and service-user groups and professionals. The need to engage in this debate about ethics and behaviour grows ever more urgent as more and more reports of poor care and overstretched staff emerge. The future of health and care professional practice depends as much upon our individual response to ethical obligations as it does on our technical competence.

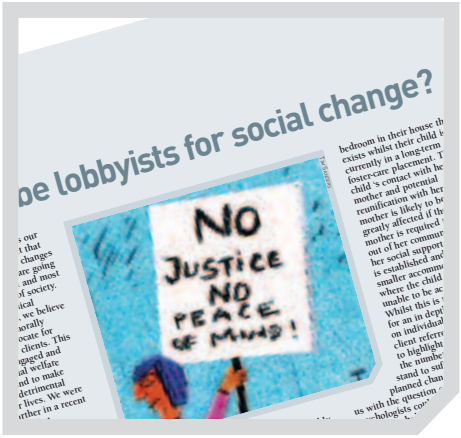
Anna van der Gaag
Chair, Health & Care Professions Council

From silence to a public voice

I was moved (both in the emotional sense and the 'moved to actions' sense) by Jade Weston and Nic Horley's letter ('Can we be lobbyists for social change?', April 2013). It reminded me of the position of the Just Therapy group (Waldegrave et al., 2003) that states that for those in the helping professions to witness the stories of hardship and how social injustices impact on the well-being of those who consult with us and to remain silent is an immoral act. It made me question why I, and my profession, have been too silent about the real and potential impacts of the current changes to health care and the welfare system on the lives of those who consult with us.

The anonymous letter in *The Psychologist*, May 2013 ('Lobbying for social change') makes the important point though that we should not idealise or romanticise poverty or other disadvantages. Unfortunately the moral high ground has never belonged to any one socio-economic group. Those from poorer backgrounds who have been so inclined have found ways to abuse the benefit system, just as some from financially more privileged positions have found ways to abuse the tax system.

In my view though this is not a moral question for the individual on whether we



are 'good' and deserving human beings (however we might want to define what that means) and thus entitled to a decent quality of life and decent services. Rather, it is a moral question for society. The welfare state holds that all are entitled to good education, good health care and a humane standard of living whatever your social circumstances. The current changes, from my perspective, change this and lead to a position where those from deprived backgrounds can find themselves unable to maintain a basic quality of life and where they no longer have access the an equal standard of healthcare provision.

In my view it is the duty of psychologists and others who witness the direct impact of changes to the benefit system and National Health Service on the lives of those who consult with us to make these impacts visible to our professional community and to society.

I was so impressed by the strong stand the DCP and BPS have taken in response to the DSM-5, highlighting the problems associated with an individualised understanding of human distress and emphasising the importance of fully acknowledging and responding to the social contexts for that distress. Maybe these challenging times are activating us as a profession to have a stronger and more political public voice and to become influential lobbyists for social change. In the meantime, Weston and Horley's letter makes it difficult for us as individual psychologists not to consider what position and action we each wish to take.

Lizette Nolte
Clinical Psychologist
University of Hertfordshire

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RETIRED... BUT STILL A PSYCHOLOGIST

As a retired independent practitioner, I am delighted that independent practitioners will hopefully now have a voice – it would have meant a lot to those practitioners like me who felt themselves marginalised. [The Society's Trustees have supported a proposal to establish a Special Group for Independent Practitioners; the next step is the vote of the membership to establish it.] Now, following on from letters to *The Psychologist* (Peter Topham, February; Harry Gray April; Janie Penn-Berwell, May), might be a good time to establish a special interest network for retired psychologists.

As Penn-Berwell indicated, leaving a lifelong profession is a form of bereavement. As an occupational psychologist I found it relatively easy to identify a workable alternative career path (copy writing) but I'm still a psychologist – sort of incognito. I think retired psychologists have lots to offer each other, the BPS and the public. By establishing a relevant group, the BPS could offer those approaching retirement good reasons for remaining active members after they've filed their Practising Certificates under 'Miscellaneous'.

Eleanor Lancaster
Bangor, N. Wales

Self-dosing and the e-cigarette

It would seem from the comprehensive review of smoking addiction in the May issue of *The Psychologist* by Lynne Dawkins that despite years of research there is still no real progress in helping smokers to quit. One significant factor in the maintenance of the habit, however, is not discussed in the article, namely the way in which smokers can automatically adjust their nicotine input to some 'optimum' level according to the perceived level of stress.

It is over 40 years ago that Heather Ashton and myself first demonstrated this behaviour in human participants (Ashton &Watson, 1970). Our study was prompted by earlier research which suggested that a smoker has 'literally finger-tip control of how much nicotine he takes into his mouth' (Armitage et al., 1968). Our study demonstrated that the effects of nicotine depend largely upon the dose and rate of self-administration by smoking and that critically the rate of self-administration is controlled more by the puff rate than by the depth of inhalation of each puff.

During a complex motor-perceptual task smokers of cigarettes with high-retention filters took more frequent

puffs obtaining nearly the same amount of nicotine as smokers of cigarettes with low-retention filters during the tasks; and in the following resting period low-nicotine cigarette smokers took more frequent puffs than those smoking high-nicotine cigarettes (participants were unaware of the different filters).

The results suggested that the smokers were striving for a nicotine-alerting effect whilst engaged in the task. Both groups of smokers also showed a significant increase in puff rate during the resting period after the tasks, and the amount of nicotine obtained per unit of time also rose during this period. This suggested that the subjects may have been attempting to obtain a 'tranquilising' effect of a higher dose of nicotine. All participants showed a slightly higher nicotine abstraction rate during the most stressful task. It was concluded that the rate of self-administration is controlled more by the puff rate than by the duration or depth of each puff.

Armitage et al. (1975) substantiated these findings using arterial nicotine concentrations as a measure of nicotine levels and concluded that smokers adjusted their way of smoking in order to achieve a desirable psychological effect – small frequent doses of nicotine produce effects associated with central stimulation (desynchronisation of electrocorticogram and increased cortical acetlycholine release) whilst larger doses given less frequently may cause depressant effects (decrease in cortical activity and acetylcholine). More recent research, such as that by Corrigal et al. (1994), has also implicated the role of dopamine release by the activation of the nicotinic acetylcholine receptors in the brain, which we suspected at the time but were unable to measure.

Although sensory and learned behavioural aspects of smoking a cigarette may have some influence on the maintenance of the habit, it would seem that with reference to the studies described above that for the electronic cigarette to be effective it must replicate the 'finger-tip control' the smoker has in varying their nicotine intake by altering their puff rate to achieve a desired pharmacologically mediated psychological effect. If it does not allow this self-dosing then the e-cigarette may be no more successful than the campaign some years ago to encourage all smokers to change to low-yield nicotine cigarettes.

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All-or-nothing thinking about NLP

All-or-nothing thinking is often regarded as inferior to the more considered thinking of the analytical mind as it is usually triggered by strong emotion, and I am surprised how often I find this type of thinking associated with those three letters NLP (neuro-linguistic programming). In my experience the polarisation that occurs is the result of a lack of understanding and education in psychologists.

The predictions in the 1980s that NLP was just another fad to come out of the Human Potential movement that will blow itself out has not eventuated and it is now stronger than ever. I know a Google search is not the most scientific way to conduct research, however on 8 April 2013 I typed in 'NLP' and I got 72.5 million hits. This is substantially more than the most popular branch of psychology, clinical psychology, which trailed behind with 51.3 million, and my own discipline occupational psychology with only 11.6 million.

Professor Rob Briner conducted a similar piece of research and Googled 'chartered occupational psychologist' associated with a number of other terms. He found NLP (84,900 hits) compared with say coaching (31,700 hits) or Belbin (674 hits) (Briner 2012). Even though Briner acknowledges these numbers are not reliable it does beg the question why should Chartered Psychologists wish to be even remotely associated with something which for some of their colleagues is the devil's spawn?

Yes there is unethical practice in NLP, yes there are numerous exaggerated claims; however this is one end of the curve; at the other end there is good, ethical and responsible practice. Often it seems psychologists make generalisations from the undesirable extreme across the whole field. On the other hand NLP practitioners deride what psychology has to offer in terms of conceptual clarity and hypothesis testing.

A typical example comes from Jon Sutton's (2012) comments in *The Psychologist* where he describes NLP as an easy target in the context of a 'series of pops'. In examining the source material I read: 'Meanwhile, the field (or cult) of "neurolinguistic programming" (NLP) sells techniques not only of self-overcoming but of domination over others' (see tinyurl.com/8jkndqc).

Tosey et al. (2009) make it quite clear in their academic review, NLP it is not a cult and the description of NLP above is frankly insulting to anyone who takes the field seriously. I often ask psychologists: Have you read about the recent applications of NLP in the field of psychotherapy (Wake et al., 2013) or coaching psychology? (Grimley 2013)? Do you know since 2008 ANLP have hosted NLP research conferences at UK universities? And are you aware there is good-quality research out there (see, for example, tinyurl.com/nlpconf) that supports NLP?. If psychologists do take time to source and read this type of material they might be able to more professionally and ethically comment on a field that has been popular since the early 1970s.

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Choice in controlling relationships

I am a barrister and former solicitor in the field of human rights, with experience in domestic violence and human trafficking cases. I hope to draw attention to the anomaly that is consent to controlling relationships, and should value your readers' views/comments on the issue. My concern is that the appearance of choice in such dynamics may not be choice at all, but a symptom of deception. This would help to explain both why victims remain in controlling relationships, and how their partners get away with subordinating them to their will.

A prerequisite to choice is knowledge of what one is choosing. Take the customer who is unwittingly sold an imitation Rolex. She does not choose the fake watch any more than she chooses to be deceived; she believes it is something different. And, logically, the same applies to a person who is deceived as to her partner's identity: she cannot choose to be with that person as such.

Critically, then, an individual's belief that she is making a choice is no guarantee that she is. And, whilst that is primarily a matter for her, it seems negligent to ignore the possibility that she is deceived as to what – or indeed who – is on offer. As the 20th-century philosopher Simone Weil (1952) observed: 'Liberty, taking the word in its concrete sense, consists in the ability to choose' (p.12). It follows that an individual who does not choose is not free. In assuming that she is, therefore, we risk reinforcing her confinement.

Whose choice?

Of course, in theory, an individual may choose to relinquish choice altogether, by submitting herself to another's will. Yet, as such, it would be her last choice, annulled the instant it was made. And, to that extent, the scenario is unimaginable, as to remain in active submission would require further/ongoing choice.

In practice and in law, even people in ostensibly controlling relationships have been found to demonstrate their capacity to make independent choices, an indication that they are not, ultimately, controlled. For example, on sentencing Mairead Philpott to 17 years in April, Mrs Justice Thirlwall recognised that her husband had treated her as a 'skivvy or a slave', but emphasised that in repeatedly refusing him a divorce, she had 'made a choice that was not his choice'. But – stepping back – if a person believes that her relationship is consensual, then is she not likely to demonstrate that belief by appearing to make independent choices, whether or not she actually is? The point is that we should expect a victim of deception to believe that she is not deceived. But whether her choice is real or illusory, will depend on whether she is deceived as to what it is she is allegedly choosing.

The fake Rolex of controlling relationships is, it seems, 'fake support'. Its peddlers present as guardian angels, unconditionally supportive of their victims' entitlement to a better life (with them, of course…). Inevitably, however, tangible signs of control start to emerge: the victim's emotional and/or geographical isolation from her loved ones, for instance, servile behaviour towards her 'partner', etc.

Yet, any critical doubt on the controllee's part as to the nature of her situation is overridden, it seems, by her desire to believe the deceiver's fanciful message. Indeed, as clinical psychiatrist Arthur Deikman (1994) astutely observed, 'wanting to believe is perhaps the most powerful dynamic in initiating and sustaining cult-like behaviour' (p.137).

'Guardian angels' target those most likely to want to believe their message of hope: the vulnerable person in need of help; the disillusioned romanticist; the idealist, etc. They pop up in the courts and in the press from time to time. Yet, by the time they do, it is usually too late for their victims. Worse still, those same victims are often labelled as accomplices to their fate. They are not, are they? Or does a slave choose her master?

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Working with media agendas

With reference to the psychologists working with the media article 'Psychology on the back seat?' (June, 2013), I would like to offer my own reflections on this experience.

It is without doubt exciting, and a bit of a giggle, to be asked to make a contribution to the media, and easier to be swept up in that excitement. Let's face it, most people would love the opportunity to be on the telly. We dress this up with thoughts of: 'what a brilliant opportunity to promote psychology', '…to promote the service/department', 'a chance to demonstrate to the public the value of psychological perspectives in understanding the human condition', 'at last! Recognition!', and 'I'll be needing a new suit'.

In my case I've made radio and television appearances to promote the Veterans Community Mental Health Service, on behalf of Tees Esk & Wear Valleys NHS Foundation Trust. The key learning point for me is that the media *always* have an agenda! Whether dealing with a director, producer or journalist, they will have already decided what direction they want the programme to go in, what they want from you, and how they want to present you, their contributor.

They make no secret of this, and if you ask them they will tell you. Where conflict begins is when the contributor is unaware of the programme's

agenda, and is seeking to follow their own agenda. So, while my agenda might be to promote the service, and the psychological perspective of veterans mental health issues. The media agenda might be that there are not enough services for veterans, and isn't it a pity?

As the producers of the programme have the editorial control, their agenda will always take prominence. So, that insightful monologue I gave succinctly relating the observed phenomenon to psychological theory, and formulating a solution, ends up on the cutting-room floor.

So, how to move forward? Talk to the producers, the directors, the presenters, the journalists, ask them how they are presenting the situation, and what perspective they are looking for from you the contributor. Assuming you are ethically comfortable with the programme agenda, then the challenge is to acknowledge that agenda, and incorporate yours into it, ideally in collaboration with the producers. Of course, if you are not comfortable with their agenda, or the programme, then you should talk to the producer about your concerns and not get involved until they are resolved. As a last resort you can approach the industry regulator. If you can facilitate the media and your own agenda, then you succeed in promoting psychology, and sharing psychological knowledge. A checklist of questions: What is the programme about?; Why do they want my input?; What is the programme agenda?; Is the programme ethically sound?; Will the participants benefit from taking part in it?; If there are vulnerable people involved, are there adequate safeguarding structures in place?; Are the participants able to give informed consent, and withdraw that consent?; Will there be follow-up care for any service users /vulnerable people involved in the programme?; How will my involvement benefit the participants, listeners, viewers, myself, and my profession?; Should I do it, what does my clinical supervisor/clinical lead think?; Is my trust's /university's or employer's communications/PR department aware of my involvement, do I need their consent and/or advice?

Phil Boyes
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The future we want?

I am writing in response to Sarah Rose's letter published in the June 2013 edition of *The Psychologist* entitled 'Clinical psychology heartache'. My aim is to emphasise the necessity of greater support and provision of opportunities for graduate psychologists. To illustrate the need for this, I feel it would be beneficial to share my own experiences, which I think are likely to be representative of many others' trials, tribulations and utter frustrations at trying to 'make it' in the psychology field.

I graduated in 2009 with a first class honours degree that was accredited by the British Psychological Society. I also won two graduate awards; one of which was the BPS Award for Undergraduate Psychology (2009). I was ecstatic with my results, and eager to pursue a professional career in psychology. I had undertaken varied work experience during my studies through being an agency

support worker, and also gained voluntary work experience in Her Majesty's Prison Service shortly after graduation.

Despite appearing to be well prepared for a future psychology career, I encountered rejection after rejection when submitting job applications after graduation. When I sought feedback from prospective employers, I kept getting the reply that I did not have sufficient or specific enough experience to be considered at the application stage. In fact, one prospective employer said to me: 'Unless you have direct experience in working with patients who have neurological disorders, don't bother to apply.' This brought the question to mind of how I was supposed to gain the experience I needed.

Eventually after months of enduring the misery of repeated rejections for the same unchanging reasons, I was able to secure a post as a psychological assistant in Her Majesty's Prison Service. The irony of this is that after all of my hard work, this job had no requirement for degree-level education. However, I had a real interest in forensic psychology, and so perceived this to be a great opportunity. The post started really well, and I absolutely loved the role. However, after one year of being in the post and receiving excellent appraisals during that time, I received a global e-mail from an Area Psychologist which included devastating news. New changes were being introduced which meant that completion of an accredited MSc would now be a requirement to apply for Forensic Psychologist in Training posts (FPiT), and that the Prison Service would no longer fund this course. I was given an ultimatum in the e-mail: either apply for upcoming FPiT posts anyway, knowing that I may be rejected at any time as soon as the changes came in, or decide not to apply.

Support?

I researched opportunities to complete the MSc but was unable to raise the funds to do this, due to considerable financial commitments. I applied for the FPiT posts anyway, but was rejected due to lacking experience of specialist risk assessments that other candidates gained as a result of working with a higher-risk population. I was devastated; once again, I'd been rejected. I kept telling myself that surely the standard of my degree would set me apart, but in fact, it was never even considered.

My next steps were to source opportunities in clinical psychology, but I faced many further rejections despite reframing my forensic experience within the context of clinical formulation and intervention. I often missed out on the chance to even apply for vacancies in the clinical field, as jobs would often open and close during the same or next working day, and I did not have internet access at work in order to apply. I also found a distinct pattern of Clinical Assistant Psychologist posts being of a temporary and/or part-time nature, or in some cases completely honorary, which entirely ruled out a chance of me applying for the role.

I left university feeling like I had a talent for psychology; something which my grades strongly imply. I was often given positive feedback about my critical thinking and original and novel approaches to assignments; and I genuinely feel that I had a lot to offer the discipline.

I must admit that I'm exhausted, frustrated, uninspired and utterly demoralised at the prospect of further pursuing a career in psychology. What I now have to manage is the intense guilt and sense of failure I feel at myself for not succeeding in this discipline. I'm not sure if or when I will ever be able to let this go. I will always tell myself that there is something more I should have done, even if right now, I genuinely cannot see what more I can do.

I have not written this letter as an opportunity to complain, but rather as a firm and resounding request for the BPS as a professional body to work in collaboration with public, private sector and voluntary organisations in order to offer support to graduates in obtaining relevant work experience. Additionally, to review the entry criteria for professional training in psychology so that this more fairly measures aptitude and the potential to contribute to psychology, as opposed to the unrealistic requirement for graduates to have secured elusive and unobtainable posts.

The above is essential if applied psychology is to avoid becoming an elitist discipline, dominated by those who have the resources to pursue academic training and short-term, ad hoc work experience placements. I feel that I have been undervalued and let down by the discipline and it is my understanding that many other graduates feel the same. Consequently, psychology runs the risk of losing many novel critical thinkers, clinicians and theorists of the future with the emergence of an elitist discipline.

Is this the future we want for psychology?

Lisa Molloy
Wiltshire

Editor's note: Society representatives have been invited to respond in a subsequent issue.

across

1 Lesson given with drug shot – this should lift the spirits (6,7)
8 Psychologist's first consideration having left gem (5)
9 Appears to have heart that's edible (3)
10 Position of control in personality psychology? (5)
12 Celebrated boisterously – scheduled about one (9)
13 Liking for smack (5)
14 Newspaper in charge of living matter (7)
15 Itinerant man one doc treated (7)
17 Part-decorated internally in 1920s style (3,4)
20 Function for each school group (7)
22 Action taken against something during dream phase (2,3)
24 I'd try to get around composition of unpleasant tasks (5,4)
25 Longs to drop number for a very long time (5)
26 Afterthought I added in Greek letter (3)
27 Rider moving large number west in less damp conditions (5)
28 Nineteen moles somehow very at home (2,4,7)

down

2 Zero assessment for declaiming (7)
3 Suddenly together (3,2,4)
4 Most of realm I caught based on practical experience (7)
5 Seed-spilling Biblical character put on continuously (2,3,2)
6 & 8 down Dual nature of Yugoslav character? (5,11)
7 Struck and worked out without hesitation (7)
8 See 6 down
11 Marches keep disturbing one who's 2 down (11)
16 Suffering short modern lines with passenger vehicle overturned (9)
18 Coach takes monarch to see landscape (7)
19 One giving name to complex work about English princess (7)
20 One-sided description of instinct in psychoanalytic theory (7)
21 Dark blue appears neat on boy (7)
23 Craftsman, parent and child (5)